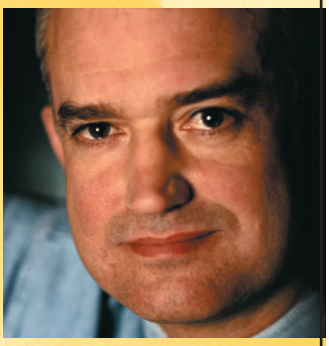
A Public Health Approach to Preventing Suicide

A break-up. A diagnosis. The loss of a job. A sense of hopelessness. For *hundreds of thousands* of vulnerable Americans each year, bad news or emotional distress triggers an impulse to end their own lives. While most people recover from temporary grief or depression to lead fulfilling lives, tragically, 30,000 resort to suicide every year.



We know that the number of suicides can be lowered. While we don't have all the answers, we're learning more each day. What we discover will help save lives.

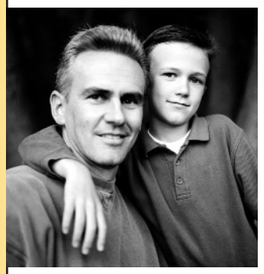
"The need for improved and expanded surveillance systems for suicide is one of the central goals of the National Strategy for Suicide Prevention. The National Violent Death Reporting System provides a promising framework."

– Institute of Medicine, National Academy of Sciences (2002)

Suicide Can Be Prevented

Suicide can be prevented – if treated like any other public health threat. The first step is knowledge.

Comprehensive data about suicide shed light on individual risk factors and community-wide trends, providing families, health professionals, law enforcement, policymakers and others with the information they need to develop prevention plans that work. When based on sound data, a range of targeted approaches have been proven to reduce suicide rates.



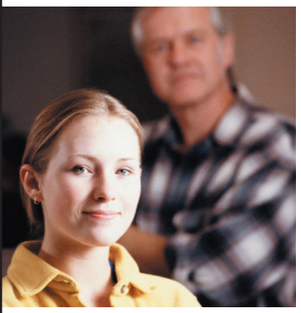
This brochure illustrates how better data collection, including the National Violent Death Reporting System, can inform prevention strategies and make a real difference.

The Toll of Suicide

Every year more Americans take their own lives than are killed in homicides – an average of one life lost every 18 minutes. Approximately 600,000 attempt suicide each year. In the past two decades, the rate of suicide among 10-14 year-olds has nearly doubled.

Suicide affects all of us. The trauma can fracture entire communities. Family members may blame themselves, adding to their pain.

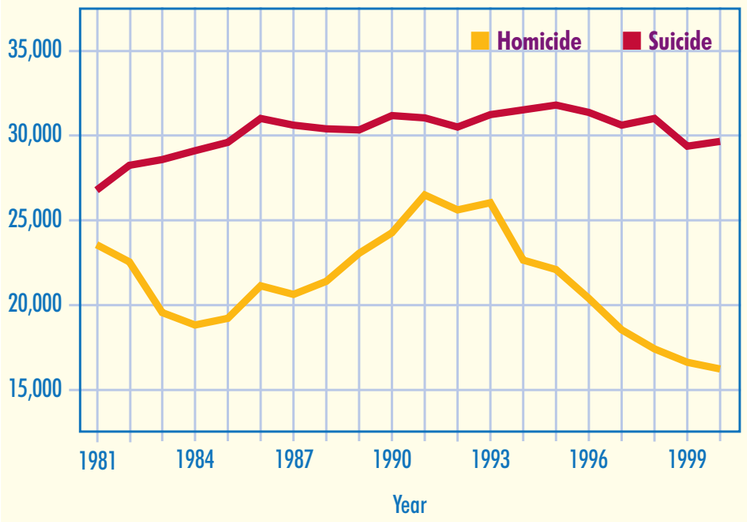
The annual economic and social loss to society is estimated to be in the billions of dollars.



CASE STUDY

A tearful 7th grader confides to a friend that he plans to kill himself. His mother's prescription medication is not hard to obtain. But his classmate heeds the lessons of a school-sponsored suicide prevention workshop and reports the conversation to their teacher. The boy and his family receive therapy that addresses his distress.

Homicide and Suicide Deaths in the U.S. 1981-2000



What We Do Know

A Split-Second Decision

Conventional wisdom says that once an individual chooses to kill himself, nothing can be done to stop him. In fact, suicide is often not the result of a calculated plan but an impulsive act of desperation that can be facilitated by the ready availability of lethal means and/or the influence of alcohol.

One study of people who made nearly-lethal suicide attempts found that for two-thirds of attempters, less than an hour elapsed between the decision to end their life and the actual attempt. For one out of four attempters, only **five minutes** elapsed. Teenagers, for whom the pressures of adolescence can sometimes seem insurmountable, are particularly vulnerable.

"From stamping out tuberculosis to increasing road safety, public health officials have proven the power of surveillance systems to minimize risks to our health."

– Georges Benjamin, MD, FACP, Executive Director, American Public Health Association

Follow-up studies of serious suicide attempters (such as those who have thrown themselves in front of a train but survived) have found that 90-95% do not go on to kill themselves. Helping people through these short-term, high-risk periods, therefore, is the goal of much suicide prevention work.

Mental Health is Fundamental

Suicide victims often have undiagnosed mental disorders such as severe depression, and many lack the skills for coping with stress and disappointment. But mental illnesses can be diagnosed just like infectious diseases, and effective therapies exist for many conditions.

More knowledge about the links between chronic mental health conditions and suicide attempts will help us screen for those at risk and get them appropriate care. The National Cancer Institute, for example, recognizing the profound impact of a life-threatening diagnosis, urges monitoring for depression as a critical component of cancer care.

A Roadmap for Prevention

In order to intervene most effectively, we must first know the facts.

The public health approach to injury prevention is evidence-based. It pools information about the "who, when, where and how" of all incidents to better understand the "why."

Accurate information about the circumstances surrounding suicides can help mental health professionals, school nurses, law enforcement officers, family members, policymakers and others to:

- **Target** their attention and offer services that intervene quickly and effectively.
- **Create** tailored public education campaigns that raise awareness about warning signs and opportunities for support.
- **Develop** community-wide policies that make it less likely for impulsive acts to end in death.
- **Evaluate** specific prevention strategies and compare local trends with other regions experiencing similar spikes or dips in suicide rates.
- **Channel** funds to programs or agencies that address the issue head-on and are proven to work.

The National Violent Death Reporting System

For too long, we have been behind the curve when it comes to acquiring information on suicide. While medical examiners, coroners and police officers often collect valuable information about the circumstances surrounding a suicide death, the information typically remains inaccessible in case folders and filing drawers.

To make use of this valuable information, in 2002 the Centers for Disease Control and Prevention (CDC) created the **National Violent Death Reporting System** (NVDRS) and funded six states to begin data collection. NVDRS will improve our understanding of suicides, as well as homicides, by collecting and linking detailed information – from death certificates, police reports and coroner or medical examiner reports – into a useable, anonymous database. Over the course of several years, if sufficient funding is available, CDC will continue to expand NVDRS to additional states until all 50 are part of the system.

CASE STUDY

A 40-year old male has a history of depression and a problem with drinking. When his wife files for divorce, he goes on a binge that takes him to a bridge once known as a local jumping spot. Discovering that a fence has been built to restrict access to the ledge, he pauses and picks up the phone connected to a suicide prevention hotline. A conversation with a counselor helps him realize the seriousness of his problems with alcohol, and leads him to seek support from friends.

Safety in Numbers: Lessons from the Road

NVDRS is modeled after a similar system operated by the U.S. Department of Transportation that has used police reports and other sources to track the facts related to all motor vehicle deaths since the 1970s. This information has led to increased seatbelt use, widened highway lanes and cars re-engineered for safety, among other life-saving innovations. These have contributed to a dramatic decline in the rate of automobile fatalities, and a quarter of a million lives saved over the past three decades.

Test-Driving NVDRS: The NVISS Pilot

We know that NVDRS can work because a successful pilot for the system has provided unprecedented insight into the circumstances that lead to suicide. The Harvard School of Public Health coordinated the pilot (called the National Violent Injury Statistics System) in partnership with a dozen organizations around the country, such as the Medical College of Wisconsin, San Francisco Department of Public Health and the University of Utah. These groups have been collecting data in six states and six counties to inform local suicide and violence prevention strategies.

"Data on suicide and suicidal behavior are needed at national, state and local levels."

– Former U.S. Surgeon General David Satcher, MD, PhD

In Lehigh County, PA, for example, data collection ended up redirecting the community's violence prevention plan. Whereas local officials anticipated that surveillance would underline the need to crack down on firearm violence tied to drug trafficking, it instead revealed the greater magnitude of a suicide crisis and reinvigorated a county-wide suicide prevention coalition. Researchers from the University of Pennsylvania worked with local officials to geocode neighborhoods at highest risk. They secured funds from the local health department for an educational campaign that used targeted billboards to promote access to a crisis hotline and forged a partnership with a payroll company to insert prevention information into employee paychecks.

Investigate
Intervene

When we know enough about the problem, informed interventions have been proven to stem the tide of suicide within a community.

From 1990 to 1994, a significant rise in suicides posed a threat to the health and safety of the U.S. Air Force. Suicide accounted for nearly a quarter of all deaths among active-duty personnel, making it the second-leading killer after unintentional injuries. In response, the Air Force implemented a comprehensive prevention strategy. A key component is their suicide surveillance system.

"We know that mental health problems are significantly related to suicide, and that mental health care services are important to reducing suicide. However, targeting those in need and matching them with effective treatments requires a public health approach that uncovers warning signs and risk factors for those in danger."

– Alan Berman, PhD, Executive Director,
American Association of Suicidology

This central database of self-inflicted injuries and deaths includes information on demographics, use of prevention services and associated psychological, social, behavioral and economic factors. Compiling this information has allowed Air Force officials to train unit leaders, chaplains and medical and mental health providers to better recognize those at risk.

For example, data collection showed that suicide victims were more likely to have criminal histories. It turned out that attorneys regularly advised Air Force defendants not to seek mental health counseling because their records might be subpoenaed. The Air Force took steps to protect the confidentiality of mental health records among its personnel and trained attorneys to recommend that defendants seek counseling if they felt distressed.

By the late '90s, the Air Force's suicide rate had declined more than 50%, to record lows, and has remained significantly below pre-intervention levels.

Reducing Availability of Lethal Means

Suicide attempts with paracetamol (acetominophen, Tylenol) steadily increased in the United Kingdom beginning in the 1970s. By 1996, nearly half of all overdose cases in general hospitals in England and Wales involved painkillers, especially paracetamol, either alone or with other drugs.

When research traced the drug's misuse to its ready availability and revealed that nearly 75% of suicide survivors said they swallowed the drug on impulse, officials decided to limit the amount sold in each package. In the two years following legislation, the number of deaths due to paracetamol overdose dropped, suggesting that reducing the number of pills in households at any given time reduces the risk of overdose.

When one method is unavailable, do suicidal people simply substitute another? Not always. In some cases, if a method that is acceptable to the person is not readily at hand during the most acute phase of a suicidal crisis, the crisis may pass – sometimes in a matter of minutes – before the person finds an alternative method.

CASE STUDY

A 65-year old railroad engineer is put on medical leave after injuring his back on the job. He becomes increasingly despondent and remains in pain for several months, with no promise of returning to work. Sensing his despair, his wife contacts a local support group, which recommends that she hide potential weapons and monitor his prescription medication. She attends meetings with him, they find meaningful activities, and he ultimately confides that he had searched the house for his old hunting rifle in a moment of desperation.

Integrating Mental Health Services

Communities that see high rates of suicide may benefit greatly from public awareness campaigns that reduce the stigma associated with seeking help for emotional distress. Can treatment really make a difference? The answer seems to be "yes." For example, one study found that when general practitioners serving the Swedish island of Gotland during the mid-1980s were trained to better screen and manage depression among their patients, the suicide rate for the community dropped to half the pre-training rate, while the rate for the rest of the country remained level.

Investigate
Intervene

Suicide is the second-leading cause of death among people aged 10 to 17. Among this age group, there is a clear and compelling case for the responsibility to intervene.

Though we know the total number of young deaths due to suicide, we know little about why, how and where these incidents occur, and whether there are windows of opportunity that we can use to change the course of events. With more information about precipitating crises, we can suggest alternatives and find ways to save young lives.

Warning Signs

Data from pilot sites indicate that **close to half of teen firearm suicide victims faced an acute crisis – such as a relationship break-up or an argument with a parent – in the two weeks preceding their death.** Family members, counselors, law enforcement and community members

alike need to be aware of the potential impact of acute stress, especially on youth, and they should consider limiting access to the most lethal means available in their immediate environments.

CASE STUDY

A teenage girl's angry outbursts land her in juvenile hall three times in one year. Because young repeat offenders are known to be at risk for suicide in her community, a counselor is assigned to her case. Working with her probation officer and a family member, they are able to help get her into appropriate treatment to address her underlying problems.

Juvenile Offenders at Risk

In a University of Utah study, data covering a three-year period revealed that **63% of youths who died by suicide in Utah had contact with the juvenile justice system, and that there was a direct correlation between the number of contacts and increased suicide risk.** Suicide completers had multiple minor offenses over many years; a significant number of youth could not be located within the school system. Few had received active psychiatric treatment. These findings point to juvenile justice as a promising site for identifying youths at risk for suicide and for delivering mental health services.

"Suicide prevention is predicated on knowing where the problems exist and who is most at risk to act in a self-destructive manner. NVDRS is a necessary first step in implementing the national suicide prevention plan."

– Mort Silverman, MD, Director, National Suicide Prevention Resource Center

For More Information

- For more information about suicide prevention, contact the **American Association of Suicidology**: (202) 237-2280; www.suicidology.org; info@suicidology.org or the **National Suicide Prevention Resource Center**: 877-GET-SPRC; www.sprc.org.
- For an Internet-based workshop on locating and using existing data systems for suicide prevention, contact the **National Suicide Prevention Training Center**, a joint project of EDC, Inc. and the Harvard Injury Control Research Center: www.ncspt.org.
- For more information about the **National Violent Death Reporting System**, contact the **Centers for Disease Control and Prevention**: (770) 488-1506; www.cdc.gov/ncipc/dvp/dvp.htm.
- For more information about the pilot for NVDRS, contact the **Harvard Injury Control Research Center's NVISS** project: (617) 432-1143; www.nviss.org; info@nviss.org.

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